NORTH VALLEY HOSPITAL

MEDICATION RECONCILIATION FORM

Patient Pharmacy: _____

_____

Allergies: _____

_____

MEDICATIONS PRIOR TO ADMISSION / TRANSFER

(Include prescriptions, herbal supplements, pumps, patches, OTC products)

Source: □ Patient □ Family/Care giver □ Prescription bottle □ Pharmacy □ Med list □ Physician(s) _____ □ Other _____

MEDICATION (Include strength)	Dose	Route	How often?	√ed by	Continue on Admission	Continue on Discharge	Comments (Last dose/Changes)	For:
1					Y N	Y N		
2					Y N	Y N		
3					Y N	Y N		
4					Y N	Y N		
5					Y N	Y N		
6					Y N	Y N		
7					Y N	Y N		
8					Y N	Y N		
9					Y N	Y N		
10					Y N	Y N		
11					Y N	Y N		
12					Y N	Y N		
13					Y N	Y N		
14					Y N	Y N		
15					Y N	Y N		
16					Y N	Y N		
17					Y N	Y N		
18					Y N	Y N		

ADMITTING PROVIDER SIGNATURE_____

Date and time_____

CONTINUE ONLY THE MEDICATIONS CIRCLED "Y" UNDER "CONTINUE ON DISCHARGE" AND ANY ADDITIONAL BELOW:

ADDITIONAL DISCHARGE MEDICATIONS

(See physician order sheet)

Medication	Dose	Route	How Often	Reason / Comment
1				
2				
3				
4				
5				
6				
7				
8				

Signature_____ Signature_____ Pt Label